ADAM SMITH INSTITUTE

BRIEFING

Unitary Medical Regulation

Serving patients, not professionals

Poor service: a bigger problem than we think

Empirical research reveals that **the majority of grievances about medical services go unvoiced**. Some 20% of patients feel they ought to complain about some aspect of the hospital services they received, and 13% about GP services. But only about a quarter will actually make the complaint.

This **reluctance of patients to complain** has many causes. For example:

- they may still be unwell and simply **do not feel up to pursuing the issue**;
- they feel **unequal in knowledge and experience** to those who treat them;
- they find it hard to segregate the **human shortcomings** of how their care was delivered from the **technical limits** of what was possible medically;
- they may wish to preserve good **long-term relationships** with doctors and hospitals because there are few, if any, local alternatives to go to instead.

Again, the research reveals that over 80% of those who wanted to make a complaint were **not told how they should proceed**. And 75% of those who did make a complaint either heard no more about it or learnt that **no action would be taken**.

In a Service that sees 4 in every 5 adults in a 12 months period, these figures point to a **large number of dissatisfied people**. A Service that makes it so difficult for patients to complain, or even to make a comment, is missing out on a vital stream of information about what it does. If it is not aware of its failures, it will be unable to correct them. Such a system must be changed.

Today's regulation does not solve the problem

The present way in which we monitor the performance of clinical providers and root out bad ones does **not encourage openness** and communication with patients and so continues to **conceal errors and poor service**.

Effective regulation of medical provision can be **burdensome and costly**, but that cannot be an excuse for not delivering it. Nor is money the limiting factor. After decades of under-resourcing, the Health Service may well be short of both doctors and money: but other factors — such as the **professional culture of clinicians** and the **poor management of information** in the NHS — are the true source of today's shortcomings.

The **cultural issues** include, for example:

- a professional culture of **paternalism and deference** that is hard to shift. This is often reflected in poor team working techniques and an unwillingness to be open to review and comparison;
- the problem that medical professionals have a **profound aversion to criticise their colleagues**. Often they feel that their career development would falter if they come to be branded as 'whistle-blowers';
- doctors never like to turn down the demands of patients, even where their time and resources are stretched. Their commitment must be applauded: but then **under-resourced providers** may prove unable to meet those demands up to a satisfactory (or even safe) standard;
- the **paternalism** with which many doctors treat their patients, neither involving them in decisions about their treatment nor even giving them adequate information about it. This **professional opacity** in turn engenders patient dissatisfaction, inappropriate treatment, and complaints.

These outmoded and inappropriate positions must be demolished by local managers, and by medical professionals themselves. Much will depend upon the next generation of entrants to the NHS workforce and the enthusiasm with which professionals strive to change their professional cultures.

Structures will have to change too. Patients naturally find healthcare issues difficult to understand. They may expect wonders from medical science, when in fact medicine is an art that is often heavily dependent on the judgement of the individual practitioner. The information imbalance makes it hard for patients to question this judgement, but the **bewildering array of official bodies** that they must deal with makes it even harder.

One of the drawbacks of self-regulation is that providers sometimes use their regulatory power to protect themselves rather than the public. Judicial and trade-union interests come to coexist within the same body. In medicine this has surely happened, while the responsibility for other functions such as education and examination standards are shared uneasily between different bodies. It is a **fragmented and chaotic framework** that cannot well serve the public because the public cannot understand it.

Management levers, such as appraisal or measures against doctors who fail to raise or respond to concerns, should be able to accomplish some valuable reform at the local level. But **management in the Health Service remains poor**, sometimes dysfunctional, and the prospects are not bright. The sheer scale of NHS provision, with a million staff caring for millions of patients, condemns any centralized management system to certain failure.

Meanwhile, many of the initiatives currently underway to spread good practice and detect and remove dangerous doctors — such as NICE, CHI, revalidation, and appraisal — may well be beneficial on many scores, but they could well serve to **add complexity,**

as far as the patient is concerned.

Better outcomes data is also essential. Everybody needs feedback in every part of their lives: we cannot improve if we do not know just how well we are doing. In medicine, the absence of good information on outcomes is a barrier against raising standards and eliminating errors.

Many medical practitioners, of course, object that it is impossible to compare health outcomes in any meaningful way. The individual circumstances of patients, the complexities of their different conditions, the differential resources available to clinicians, and the absence of a common data set all conspire against such comparisons. However, we will never start to tease out the importance of these differences, and separate good from bad practice, if we do not start the process — while remaining mindful of its shortcomings.

This **benchmarking** concept has a long way to go today. Agreement is needed on measures of effectiveness for particular procedures in order to underpin a process of constant team and peer review, benchmarked against targets, national standards and best practice.

There is also a huge **information management challenge** in collecting, processing, and using the information to help change and improve the way medicine is practised.

Accountability and incentives are also an essential part of the approach. To be effective, the system must be supported by **open and independent inspection**, with published reports detailing the performance of individual providers. Greater rewards should go to those who exceed the standards, but there must be incentives against poor performance too: the US practice of withholding funding from a failing institution might provide a model.

Doctors of course worry that a shift to 'defensive medicine' could be the unintended consequence of greater oversight and inspection. But two facts mitigate against this resistance to reform:

- first, the fact remains that no medical procedure should be undertaken without an explicit belief that it is likely to improve the outcome for the patient. It is essential for us to try to measure that likelihood and that outcome if we are to know whether that belief was sound. If doctors are using their judgement on the basis of **good information about outcomes**, they are actually better protected, not more exposed;
- second, a good deal of litigation today comes from patients who say that they really only wanted an **explanation, or an apology**, for the service failure or adverse outcome that they suffered. Again, if doctors can show that they were working on the basis of good outcomes information, it is easier for them to give that information or apology without the threat of subsequent litigation.

Indeed, there is a strong case that **95% of complaints arise and should be dealt with at the local level**. It is at that level where the real gains are to be made, and that is where an effective complaint procedure and redress mechanism must be instituted. Few patients actually relish the idea of taking their complaint to the courts, but they will if they feel they are being ignored.

To be fully accessible and transparent, this more localised mechanism must be **coherent, with common procedures across all forms of health provision** — including hospital services, dentists, nurses, opticians — in both public and private sectors.

The government's 'near miss' strategy will work only insofar as near misses are actually detected by doctors. But today, for reasons already mentioned, doctors often never get to hear about shortcomings that were, for the patient, not even a near miss but a clear miss. Equally, there may be problems of which the patient is actually unaware, because of a lack of medical knowledge. These two points underscore the need for **first-rate information systems** and a much greater **involvement of patients** in their own treatment on the basis of greater openness and better communication from doctors.

Defining an effective complaints and redress procedure

The essential elements of an effective complaints and redress mechanism closely reflect:

- the five principles identified by the Better Regulation Taskforce;
- the structure advocated by the Independent Healthcare Association; and
- the key points arising at the Adam Smith Institute's House of Commons workshop on regulation and other interviews conducted by the Institute among leading academics and senior members of the Royal Colleges.

Function. The **function** of medical regulation from the patient's perspective is to provide:

- **information and openness** — with clear disclosure on the proposed medical procedure and the expected outcome, relative to a benchmark, the patient is empowered and can make informed judgements;
- **protection** by ensuring a standard of safe, appropriate and good quality practice arising from actions by healthcare providers, in the public and private sectors;
- **a process** that offers simplicity and accessibility, speed of response, and balanced and impartial decision-making; and
- **a mechanism to prevent mistakes recurring**.

Management. The local management must set up the process, delivering constant review, within teams and by peers, identifying incidents and near misses. There must be a commitment to quality shared by staff and managers, with leadership from the top. And it must be properly resourced.

Information. There must be a data set and information system that will provide the infrastructure for measuring, monitoring and benchmarking procedures, costs and outcomes.

Openness and communication within teams and with patients has proved to be the most effective means of improving management and empowering 'consumers' in many service sectors. Publishing **league tables** will prove an important part of the process, but these should not be limited to comparing the overall performance of trusts. Over time, as data becomes more reliable, they need to drill down to compare the performance of individual units and practitioners, and the outcomes of different procedures on different groups.

Scope. In a citizen-centred system, it is important is that any mechanism for dealing with complaints and shortcomings is **safe**, **appropriate**, and offers a **high-quality service**.

Process. The starting point must be **local** — where the event took place — but to be intelligible to patients, the complaints and redress procedure must be **coherent** across all aspects of healthcare.

Principles of good regulation

The regulation of clinical practice must focus on the clinical service standards that are delivered to patients, and not on protecting professional self-interest. It must be accepted and trusted as such by the public.

We envisage therefore a single regulatory authority that is independent of the healthcare professions. It should be dominated by lay representatives, and perhaps chaired by a lawyer rather than a clinician.

The goal in designing a new professional regulatory authority will be a mechanism that secures public acceptance by being simple, transparent, accountable, targeted and proportionate in its actions.

The authority must also be able to act with speed in assessing complaints and administering sanctions or censure.

Its scope of the authority should cover all health services, public or private. There should be an emphasis on the appropriateness of the service provided given the patient's need, rather than on the narrower issue of a clinician's fitness to practice.

Our tentative conclusion is that a new system for reviewing and redressing complaints, errors, and shortcomings in healthcare should be:

- **minimalist** — concerned solely with safe practice and effective outcomes;
- **a one-stop shop** — unitary, coherent regulation across all health services;
- **independent of professions** — with a predominance of lay members;
- **transparent, accountable, targeted, consistent, and proportional**;
- **trusted and accepted** by the media and the public;
- **accessible locally** and able to resolve most issues in the local context.